Health Policy Commission Board
April 6, 2015

Dear Sirs and Madams:

I would like to submit this email as testimony towards the formation of the regulations for the new ICU Staffing Law in Massachusetts. By way of background, I have been a registered nurse since 1978 and have worked in tertiary care hospitals as well as community hospitals in New York, Connecticut, and Massachusetts. I have held staff nurse, nurse educator, clinical specialist, nursing director, and chief nursing officer positions throughout my career. I have attended several hearings regarding the legislation as well as the regulations, most recently at Worcester State University. I would like to focus my comments in several areas:

- Recognition of Differences in Community Hospital v. Tertiary Hospital ICUs
    - The HPC should recognize in the regulations that there are very many differences between these two entities. Tertiary hospitals may have multiple, specialty ICUs such as an Open Heart Unit, Neurosurgery ICU, Pediatric ICU, Neonatal ICU, Burn Unit, etc. These institutions, typically located in larger cities have need for specialized care and the various units may often be filled to their capacity. My experience in two different community hospitals in Massachusetts is much different. There is typically only one ICU in the institution; instead of being large (10 to 20 beds) they are 10 beds or less (Harrington Hospital has 6 beds); on a daily basis there are non-ICU patients being boarded. The boarded patients, if on a general medical surgical floor, would be part of a 4 or 5 or 6 patient assignment. However, we board patients in the ICU when necessary to both give the scheduled ICU staff meaningful work to do as well as balance the workflow and load between units within the hospital. The boarded patients do not require 1 to 1 or even 1 to 2 ratio care.
        - Option: Do not define and ICU patient as any patient in the ICU but define it as any patient requiring either critical care nursing or critical care medical care.
- Recognition the statement, “at all times” has on staffing.
    - If a 1 to 1 or 1 to 2 patient assignment is maintained at all times, this means that extra nurse(s) would need to be scheduled each shift to accept the primary nurse’s assignment for any breaks, meal coverage, patient transports, etc. This creates not only a great expense but much poorer productivity and efficiency in the ICU. Nurses are professional staff and do not take risks on caring for their patients. Often times ICU patients are stable and need no active intervention or assessment during a break or meal time. There is always a hand off between nurses when one is leaving the care or a patient to another nurse; while we always need to be prepared for the unexpected change in status, there is sufficient monitoring and redundancy to manage this. If the unit’s patients are all very labile and unstable, then there is always plans for assuring additional staffing or other alternative so that the patients are cared for appropriately.
        - Option: Remove the language, “at all times” and allow the judgement to be made by the ICU staff and supervisor at the time.
- Controversy of 1 to 1 being the default ratio
    - I believe the compelling argument made by the pediatric nurse (educator) at the Worcester State University hearing should be the basis in general rather than an arbitrary 1to 1 or 1 to 2 ratio. The professional societies have researched backed guidelines for staffing the various levels/severities of patients. My wife is a neonatal ICU

nurse and has worked in several different NICUs. In a single NICU there may be very critically ill neonates as well as neonates who have stabilized and progressed over a period of time. Typically the more stable patients may be part of a 3 or 4 patient assignment as they have become healthy infants and they are only in the NICU for further growth before discharge home. It makes no logical sense to mandate 1 to 1 staffing for these types of patients just because of their location (same point as first bullet).
        - Option: Allow the regulations to also follow professional society standards. This would be not only for the NICU example above but also for other critical care areas.
- Acuity Tool and Advisory Committee
    - Many companies have developed acuity tools that the HPC and DPH should find acceptable. The tools with which I have had experience all have capabilities to make them adaptable to a specific area or culture. However, they also bring the advantage of years of research, experience, and modifications as well as a large comparative database. These companies should not be discounted as options by the Advisory Committee. It strikes me that the language and some of the testimony make the Advisory Committees sound like a labor relations meeting whereby 50% (or more) should be staff and not managers. The advisory committee should contain people who are knowledgeable about the care of the critically ill patients, be they staff nurses, nurse educators, managers, or others. Decisions should be made by consensus.
- Quality Indicators
    - It seemed to me that the 4 indicators given by the HPC for final consideration would work well as long as the "fall" indicator was modified to be only "falls with injury." I agree with the various testimonies that the indicator around pain is not the best for being nurse sensitive as it is so arbitrary.

Thank you very much for allowing me to submit my comments for your consideration.

Thomas W. Hijeck, RN, MS
Vice President, Patient Care Services
Chief Nursing Officer

Harrington Hospital
100 South Street
Southbridge, MA 01550

Phone 508-764-5065
Fax 508-909-7715